BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition to Revoke Probation of: SURINDER PAI KAUR RAI 1271 Washington Ave., Unit 328 San Leandro, CA 94577 Registered Nurse License No. 415461 Respondent	Case No. 2005 - 215

DEFAULT DECISION AND ORDER

The attached Default Decision and Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in the above entitled matter.

This Decision shall become effective on **May 22, 2008**.

IT IS SO ORDERED **April 22, 2008.**

LaFrancine W Tate

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

EDMUND G. BROWN JR., Attorney General
of the State of California
WILBERT E. BENNETT
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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition to Revoke Probation Against: **SURINDER PAI KAUR RAI** **1271 Washington Avenue, Unit 328** **San Leandro, CA 94577** **Registered Nurse License No. RN 415461** Respondent.	Case No. 2005-215 OAH No. N2008010186 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

Respondent SURINDER PAI KAUR RAI, was served with Petition to Revoke Probation No. 2005-215; Statement to Respondent; Notice of Defense forms; copies of Government Code section 11507.5, 11507.6 and 11507.7; Request for Discovery; and Recommended Disciplinary Guidelines by both first class and certified mail on September 27, 2007, at the address of record, as provided in section 11503 and 11505 of the Government Code of the State of California. A copy of the Petition to Revoke Probation is attached as Exhibit A, and is herein incorporated by reference.

The domestic return receipt indicated that the above-referenced documents were received at respondent's address of record on September 29, 2007.

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Respondent failed to file a Notice of Defense within 15 days after service of the Petition to Revoke Probation. Consequently, the Board of Registered Nursing ("Board") has determined that respondent is in default and has waived her right to a hearing to contest the merits of the Petition to Revoke Probation, pursuant to Government Code section 11520, and hereby makes the following findings of fact:

FINDINGS OF FACT

1. Ruth Ann Terry, MPH, RN (Complainant) brings this Petition to Revoke Probation solely in her official capacity as the Executive Officer of the Board of Registered Nursing.

2. On or about August 31, 1987, the Board of Registered Nursing ("Board") issued Registered Nurse License Number RN 415461 to respondent SURINDER PAI KAUR RAI ("respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expired on November 30, 2008, unless renewed.

3. This Petition to Revoke Probation is brought before the Board of Registered Nursing (Board), under the authority of the following section of the Business and Professions Code (Code). All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may take disciplinary action against any licensee, including a licensee holding a temporary or inactive license, for any reason provided in the Nursing Practice Act.

5. In the Matter of the Accusation Against SURINDER PAL KAUR RAI, Case No. 2005-215, the Board of Registered Nursing issued a decision, effective May 10, 2006, in which Respondent's Registered Nurse License No. 415461 was revoked, however, the revocation was stayed and Respondent's license was placed on probation for a period of three (3) years with certain terms and conditions. A copy of that decision is attached to the Petition to Revoke Probation as Exhibit A, and is herein incorporated by reference.

6. The conditions of respondent's probation state that respondent shall comply, inter alia, with the following terms:

A. Condition 1: Respondent shall timely submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision.

B. Condition 2: Respondent shall fully comply with the conditions of the Probation Program established by the Board and shall cooperate with representatives of the Board in its Program. Respondent shall inform the Board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license with the Board, including during any period of suspension.

C. Condition 5: Respondent, during the period of probation, shall submit such written reports/declarations and verification of actions under penalty of perjury, as required by the Board. These reports/declarations shall contain statements relative to respondent's compliance with all the conditions of the Board's Probation Program. Respondent shall immediately execute all release of information forms as may be required by the Board or its representatives.

D. Condition 7: Respondent shall obtain prior approval from the Board before commencing or continuing any employment, paid or voluntary, as a registered nurse. Respondent shall cause to be submitted to the Board all performance evaluations and other employment-related reports as a registered nurse upon request of the Board.

E. Condition 8: Respondent shall obtain prior approval from the Board regarding her level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse, or education and training that includes patient care.

F. Condition 11: Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $12,420.75. Respondent shall be permitted to pay these costs in a payment plan approved by the Board.

CAUSES TO REVOKE PROBATION

7. Respondent is subject to revocation of her disciplinary probation in that she failed to comply with Condition 1 of her probation by failing to submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision (original due date

September 23, 2006). Said forms were provided to respondent by a Board representative in a request dated August 10, 2006. Respondent also failed to respond to additional requests by a Board representative for said forms and fees dated November 20, 2006, December 28, 2006, January 26, 2007, and May 15, 2007, mailed to respondent's address of record.

8. Respondent is subject to revocation of her disciplinary probation in that she failed to comply with Condition 5 of her probation by failing to submit written reports/declarations and verification of actions as follows:

A. Respondent failed to submit the required Data Report form originally due August 22, 2006. Said form was provided to respondent by a Board representative in requests dated April 7, 2006 and August 10, 2006. Respondent also failed to respond to additional requests by a Board representative for said form dated November 20, 2006, December 28, 2006, January 26, 2007, and May 15, 2007.

B. Respondent failed to submit the Cost Recovery Payment Plan form due August 22, 2006. Said form was provided to respondent by a Board representative in a request dated August 10, 2006. Respondent also failed to respond to a second request by a Board representative for said form dated January 26, 2007.

C. Respondent failed to submit the Release of Confidential Information form due August 22, 2006. Said form was provided to respondent by a Board representative in a request dated August 10, 2006. Respondent also failed to respond to a second request by a Board representative for said form dated January 26, 2007.

D. Respondent failed to submit a current resume or work history for the past five years due August 22, 2006. Said request was made to respondent by a Board representative in a request dated April 7, 2006. Respondent also failed to respond to additional requests by a Board representative for said form dated August 10, 2006, November 20, 2006, December 28, 2006, January 26, 2007, and

May 15, 2007.

E. Respondent failed to submit a list of educational courses completed in the past two years due April 24, 2006. Said request was made to respondent in a letter dated April 7, 2006. Respondent also failed to respond to additional requests by a Board representative for said list dated November 20, 2006, December 28, 2006, and January 26, 2007.

F. Respondent failed to submit her current daytime telephone number due April 24, 2006. Said request was made to respondent by a Board representative in a request dated April 7, 2006. Respondent also failed to respond to a second request by a Board representative for said information dated January 26, 2007.

G. Respondent failed to submit, if working, a job description of her current registered nurse position, organization chart of facility, recent performance evaluations and telephone number of supervisor due April 24, 2006. Said request was made to respondent by a Board representative in a letter request dated April 7, 2006.

H. Respondent failed to submit a single Quarterly Report. Said form was provided to respondent in a request by a Board representative dated January 26, 2007. Respondent also failed to respond to a second request by a Board representative for said information dated May 15, 2007.

I. Respondent failed to submit proof of a dentist appointment on December 4 or 5, 2006. Respondent left a voice mail message with her probation monitor indicating that she was unable to attend her scheduled December 5, 2006 orientation interview because she needed to have a tooth pulled. A request to submit proof was made to respondent in letters dated December 28, 2006 and January 26, 2007.

J. Respondent failed to submit an explanation in writing as to why she has not complied with the request to submit the requested documents and

information set forth above by May 30, 2007. Said request was made to respondent in a Letter of Warning dated May 15, 2007. Respondent failed to appear at her orientation interview on August 9, 2006. As a result, orientation interviews were scheduled for August 22, 2006, December 5, 2006, and January 25, 2007. Notices to appear were mailed to her at her address of record by a Board representative and respondent was requested to bring the following documents: current resume or work history for past five years, list of educational courses completed in the past two years, recent photo identification and registered nurse license. Respondent failed to appear for any of the scheduled orientation interviews.

9. Respondent is subject to revocation of her disciplinary probation in that she failed to comply with Condition 11 of her probation by failing to submit or cause to be submitted, any amount towards Board costs of investigation and prosecution in the amount of $12,420.75.

10. Respondent is subject to revocation of her disciplinary probation in that she failed to comply with the Board's Probation Program (Condition 2) as follows:

A. Respondent failed to comply with Conditions 1, 5, 7, 8 and 11 of her probation.

B. Respondent failed to appear at orientation meetings scheduled for August 9, 2006, August 22, 2006, December 5, 2006, and January 25, 2007. Respondent failed to contact her probation monitor to inform her that she would not appear at the orientation meetings scheduled for August 9, 2006, August 22, 2006, December 5, 2006, and January 25, 2007. Meeting letters were mailed to respondent's address of record by a Board representative on or about July 21, August 10, November 20 and December 28, 2006.

11. Grounds exist for revoking probation and reimposing the order of revocation of respondent's registered nurse license as described in Condition 12, in that she failed to comply with Conditions 1, 2, 5, 7, 8 and 11 of her probation as set forth in Paragraphs 7-

10, above.

DETERMINATION OF ISSUES

Based on the foregoing Findings of Fact, respondent has subjected her license to discipline under Business and Professions Code section 2750 and has subjected her disciplinary probation to revocation under the terms of the Board's decision.

LOCATION OF RECORD

The record on which this Default Decision is based, is located at the Sacramento office of the Board of Registered Nursing.

ORDER

IT IS SO ORDERED that Registered Nurse License No. 414461, heretofore issued to SURINDER PAI KAUR RAI, is revoked in that the probation that was granted by the Board of Registered Nursing in Case No. 2005-215 is revoked, thereby imposing the revocation order that was stayed.

Pursuant to Government Code section 11520(c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on MAY 22, 2008.

It is so ORDERED APRIL 22, 2008

La Francene M Tate

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

Attachments:

Exhibit A: Petition to Revoke Probation

03579110SF2006403020
90079437.wpd

Exhibit A

Petition to Revoke Probation

EDMUND G. BROWN JR., Attorney General
of the State of California
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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition to Revoke Probation Against: **SURINDER PAI KAUR RAI** **1271 Washington Ave., Unit 328** **San Leandro, California 94577** Registered Nurse License No. 415461 Respondent.	Case No. 2005-215 **PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, MPH, RN (Complainant) brings this Petition to Revoke Probation solely in her official capacity as the Executive Officer of the Board of Registered Nursing.

2. On or about August 31, 1987, the Board of Registered Nursing ("Board") issued Registered Nurse License Number 415461 to respondent SURINDER PAL KAUR RAI ("respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2008, unless renewed.

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PRIOR ACTION

3. In a disciplinary action entitled *In the Matter of the Accusation Against SURINDER PAL KAUR RAI*, Case No. 2005-215, the Board of Registered Nursing issued a decision, effective May 10, 2006, in which respondent's Registered Nurse License was revoked. However, the revocation was stayed and respondent was placed on probation for a period of three (3) years with certain terms and conditions. A copy of that decision is attached as Exhibit A and is incorporated by reference.

4. The conditions of respondent's probation state that respondent shall comply, inter alia, with the following terms:

A. Condition 1: Respondent shall submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision (referenced in paragraph 3, above.)

B. Condition 2: Respondent shall fully comply with the conditions of the Probation Program established by the Board and shall cooperate with representatives of the Board in its Program. Respondent shall inform the Board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license with the Board, including during any period of suspension.

C. Condition 5: Respondent, during the period of probation, shall submit such written reports/declarations and verifications of actions under penalty of perjury, as required by the Board. These reports/declarations shall contain statements relative to respondent's compliance with all the conditions of the Board's Probation Program. Respondent shall immediately execute all release of information forms as may be required by the Board or its representatives.

D. Condition 7: Respondent shall obtain prior approval from the Board before commencing or continuing any employment, paid or voluntary, as a registered nurse. Respondent shall cause to be submitted to the Board all performance evaluations and other employment-related reports as a registered nurse upon request of the Board.

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E. Condition 8: Respondent shall obtain prior approval from the Board regarding her level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse, or education and training that includes patient care.

F. Condition 11: Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $12,420.75. Respondent shall be permitted to pay these costs in a payment plan approved by the Board.

JURISDICTION

5. This Petition to Revoke Probation is brought before the Board of Registered Nursing, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

6. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

CAUSES TO REVOKE PROBATION

7. Respondent is subject to revocation of her disciplinary probation in that she failed to comply with Condition 1 of her probation by failing to submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision (original due date September 23, 2006). Said forms were provided to respondent by a Board representative in a request dated August 10, 2006. Respondent also failed to respond to additional requests by a Board representative for said forms and fees dated November 20, 2006, December 28, 2006, January 26, 2007, and May 15, 2007, mailed to respondent's address of record.

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dated April 7, 2006 and August 10, 2006. Respondent also failed to respond to additional requests by a Board representative for said form dated November 20, 2006, December 28, 2006, January 26, 2007, and May 15, 2007.

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G. Respondent failed to submit, if working, a job description of her current registered nurse position, organization chart of facility, recent performance evaluations and telephone number of supervisor due April 24, 2006. Said request was made to respondent by a Board representative in a letter request dated April 7, 2006.

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J. Respondent failed to submit an explanation in writing as to why she has not complied with the request to submit the requested documents and information set forth above by May 30, 2007. Said request was made to respondent in a Letter of Warning dated May 15, 2007. Respondent failed to appear at her orientation interview on August 9, 2006. As a result, orientation interviews were scheduled for August 22, 2006, December 5, 2006, and January 25, 2007. Notices to appear were mailed to her at her address of record by a Board representative and respondent was requested to bring the following documents: current resume or work history for past five years, list of educational courses completed in the past two years, recent photo identification and registered nurse license. Respondent failed to appear for any of the scheduled orientation interviews.

9. Respondent is subject to revocation of her disciplinary probation in that she failed to comply with Condition 11 of her probation by failing to submit or cause to be submitted, any amount towards Board costs of investigation and prosecution in the amount of $12,420.75.

10. Respondent is subject to revocation of her disciplinary probation in that she failed to comply with the Board's Probation Program (Condition 2) as follows:

A. Respondent failed to comply with Conditions 1, 5, 7, 8 and 11 of her probation.

B. Respondent failed to appear at orientation meetings scheduled for August 9, 2006, August 22, 2006, December 5, 2006, and January 25, 2007. Respondent failed to

contact her probation monitor to inform her that she would not appear at the orientation meetings scheduled for August 9, 2006, August 22, 2006, December 5, 2006, and January 25, 2007. Meeting letters were mailed to respondent's address of record by a Board representative on or about July 21, August 10, November 20 and December 28, 2006.

11. Grounds exist for revoking probation and reimposing the order of revocation of respondent's registered nurse license as described in Condition 12, in that she failed to comply with Conditions 1, 2, 5, 7, 8 and 11 of her probation as set forth in Paragraphs 7-10, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking the probation that was granted by the Board of Registered Nursing in Case No. 2005-215 and imposing the disciplinary order that was stayed, thereby revoking Registered Nurse License No. 415461, issued to SURINDER PAL KAUR RAI;

2. Taking such other and further action as deemed necessary and proper.

DATED: 9/5/07

Elliot Hochberg for
RUTH ANN TERRY, M.P.H, R.N
Executive Officer
BOARD OF REGISTERED NURSING
STATE OF CALIFORNIA
State of California
Complainant

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Exhibit A

Decision and Order

BOARD OF REGISTERED NURSING Case No. 2005-215

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: SURINDER PAL KAUR RAI P.O. Box 699 San Leandro, California 94577 Registered Nurse License No. 415461, Respondent.	Case No. 2005-215 OAH No. N2005110339

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on May 10, 2006.

IT IS SO ORDERED April 10, 2006.

Board of Registered Nursing

La Francine W Tate

President

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: SURINDER PAL KAUR RAI P.O. Box 699 San Leandro, California 94577 Registered Nurse License No. 415461, Respondent.	Case No. 2005-215 OAH No. N2005110339

PROPOSED DECISION

This matter was heard before Michael C. Cohn, Administrative Law Judge, State of California, Office of Administrative Hearings, in Oakland, California, on February 6, 2006.

Complainant Ruth Ann Terry, M.P.H., R.N., Executive Officer of the Board of Registered Nursing, was represented by Kim M. Settles, Deputy Attorney General.

Respondent Surinder Rai was present and was represented by Randall Crane, Attorney at Law.

The matter was submitted for decision on February 6, 2006.

FACTUAL FINDINGS

1. On August 31, 1987, the Board of Registered Nursing issued registered nurse license number 415461 to respondent Surinder Pal Kaur Rai. The license has been renewed through November 30, 2006. No prior disciplinary action has been taken against the license. Before coming to the United States in 1981, respondent had worked as a nurse in her native India since about 1972.

2. In September 2003, respondent was employed as a registered nurse at Parkview Healthcare Center, a skilled nursing facility in Hayward. Parkview has a capacity of 120 patients. In September 2003, the facility was typically staffed with four charge nurses, one for each of the facility's four wings, and an RN supervisor, who oversaw the charge nurses. Most often, the charge nurses were licensed vocational nurses. Only occasionally did a registered nurse serve as a charge nurse.

3. "Patient A" was an 80-year-old resident of the facility. Because the patient could not swallow, she had a gastronomy tube (G-tube) inserted through the abdominal wall and into the stomach, by which route she received liquid formula, water, and medications.

4. On September 21, 2003, respondent was the RN supervisor on the 7:00 a.m. to 3:30 p.m. day shift. She was responsible for administering IV antibiotics to one patient, and for overseeing the four LVN charge nurses caring for the 119 patients then in the facility.

5. When respondent arrived for work on September 21, 2003, LVN Schola Idem, the night shift charge nurse for North 2, the wing in which Patient A resided, reported that the patient's G-tube had come out after she had been given medications at 6:00 a.m. Idem told respondent that she and one of the other charge nurses, LVN Amarjit Kaur, were unable to reinsert the tube because the stoma was closing, so they cleaned and dressed the stoma. Respondent told Idem she should have had the patient transferred to the hospital.

6. According to a written statement respondent provided an investigator, after this conversation LVN Marie Fe Fabian, the day shift charge nurse on North 2, arrived for work and Idem reported to her what had happened with the patient's G-tube. Respondent then left to attend to a patient who required IV antibiotics. Respondent returned around 7:45 a.m. and saw Fabian in Patient A's room. When she entered, respondent saw Fabian attempting to reinsert the G-tube. Idem was present and was holding the patient's hand. Respondent testified that she asked Fabian, "Why are you doing [this]? Why didn't you send the patient to the hospital?" to which Fabian replied, "It's easy to do. I did it last week. It's no problem." Idem then left and respondent remained in the room, holding the patient's hand to comfort her while Fabian attempted to reinsert the tube. Fabian twice unsuccessfully tried to reinsert the tube. At that point, according to her written statement, respondent advised Fabian to transfer the patient to the hospital. Respondent testified that certified nurse assistant Lester Mallari, who had entered the room after Idem left, also told Fabian to send the patient to the hospital when she was unable to reinsert the G-tube, and that Fabian challenged him for telling her how to do her job. Respondent testified that Fabian then asked her if she wanted to reinsert the G-tube, but that she told Fabian she had no experience with the procedure and once again said the patient should be sent to the hospital. Respondent then left Patient A's room to check the patient receiving IV antibiotics.

When respondent returned from attending to the other patient around 8:30 or 8:45 a.m. she again saw Fabian in Patient A's room. Respondent found that Fabian had inserted a G-tube and was checking its placement with a stethoscope. When asked how she had inserted the tube, Fabian said she had used a smaller size G-tube and it had gone in easily, without any problems. After checking the tube while injecting air and listening for the appropriate sounds, Fabian told respondent the tube was properly placed. Respondent did not check the tube's placement herself. When interviewed by Parkview's director of nursing on September 23, 2003, respondent said she had no further contact with the patient during the course of her shift, which ended at 3:30. In her testimony, however, respondent stated that she had checked on the patient about four times – at about 10:00, 12:00, 1:30, and

3:00. Respondent said she checked the patient's abdomen for changes, but never charted this.

7. Neither Fabian nor respondent made any entries in the patient's chart concerning the reinsertion of the patient's G-tube. Fabian told investigators that she had failed to do so because she had such a busy day. Respondent testified that she did not view it as her responsibility as an RN supervisor to chart the reinsertion of the tube – that was the charge nurse's responsibility.

8. At 4:45 p.m., the night shift charge nurse found that Patient A's abdomen was distended. She called the RN supervisor for a second opinion. Apparently believing the patient was impacted, the nurses removed stool and gave the patient Milk of Magnesia. When the patient's condition seemed to be worse around 11:00 p.m., her doctor was called. He ordered that the patient be transferred to the emergency room. Patient A was transferred to St. Rose Hospital, where she died the next day. An autopsy found that her death was attributable to peritonitis caused by placement of the G-tube.

9. Complainant alleges that respondent was grossly negligent in that she "failed to appropriately assess and notify a physician and/or transfer [Patient A] to a hospital" and "failed to intervene to prevent a subordinate licensed vocational nurse from attempting and completing reinsertion of the [G-tube] without benefit of a physician's orders." Complainant also alleges that respondent "failed to properly treat Patient A" in that should not have allowed a smaller G-tube to be inserted and in that she "failed to document the reinsertion of the feeding tube on the patient's chart and failed to document any further general or abdominal physical assessments of the patient during the entire day shift."

10. Parkview's written protocols concerning the change and replacement of G-tubes provide that tubes are to be changed or reinserted only upon a physician's order, and that the replacement tube must be of the size ordered by the physician. The first of 24 identified steps in the G-tube procedure is, "Obtain physician's orders for change or replacement."

Patient A's chart did not contain a standing order from her physician, Frank Ryning, M.D., regarding change or replacement of the G-tube. Idem told investigators that she had called Dr. Ryning to notify him that the patient's G-tube had become dislodged and had left a voice mail message but had not received a return call from him.

11. Respondent never checked Patient A's chart for physician's orders. She never asked the LVNs if they had checked. Respondent did not call Dr. Ryning. She did not ask the LVNs if they had called him. Respondent did not check Parkview's written protocols concerning the change or replacement of a G-tube before Fabian attempted reinsertion. She did not ask Fabian if she had checked the protocols. Respondent testified that after Fabian inserted a smaller G-tube she told her to call Dr. Ryning to tell him this, but she never followed up to see if Fabian made that call.

12. Respondent asserted that she did not check the chart for physician's orders, did not call the physician, did not check Fabian's placement of the G-tube, and did not make any chart entries because she was relying upon the LVNs. Respondent had worked with Fabian for about three years at Parkview and believed she was a competent nurse. She had no reason to think that Fabian was not properly performing her nursing duties, or to disbelieve anything Fabian told her. She had similar views about Idem. In addition, respondent asserted that it is the duty of the charge nurse, not the RN supervisor, to check for physician's orders, and that she assumed that Idem and/or Fabian had done so and were acting in accordance with those orders.

13. Registered nurse Rayann Goebel was director of nursing at Parkview in September 2003. She had started in that position about nine months earlier and she left Parkview in the first half of 2004. After learning of Patient A's death, she interviewed all of the staff members involved. Goebel suspended both respondent and Fabian. After issuance of the coroner's report in October 2003, respondent was terminated from Parkview. Fabian would have been terminated but resigned first.

14. Parkview Healthcare Center was owned by Mariner Post-Acute Network, a nationwide health care provider. Mariner's written job description for charge nurse provided that either a registered nurse or a licensed practical or vocational nurse could act as a charge nurse. The duties of the position included performing "nursing assessments" of residents, making rounds every two hours "to assess physical and emotional status and to initiate any required nursing interventions," and performing or supervising "the administration and documentation of . . . enteral nutrition and treatments per the physician's order and accurately record[ing] all care provided." No written job description was provided for the position of RN supervisor. Goebel testified that the RN supervisor served as a resource to the LVN staff and was responsible for assessing residents for changes in their medical conditions. She testified that it is not within the scope of practice of an LVN to perform assessments, but she acknowledged that the Mariner/Parkview job description did make the charge nurse, whether an LVN or an RN, responsible for patient assessments.

15. Goebel testified as an expert witness for complainant. She defined gross negligence as a substantial departure from the standard of care. She concluded that respondent had substantially departed from the standard of care in five respects: 1) she did not assess the resident for a change in condition; 2) she should not have permitted reinsertion of the G-tube without physician's orders; 3) she failed to stop Fabian from attempting to reinsert the tube when Fabian encountered difficulties; 4) she did not have the patient transferred to an acute care facility; and 5) she failed to document anything in the patient's chart. No contrary expert testimony was offered.

In title 16, California Code of Regulations, section 1442, the board has defined gross negligence to include "an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse." Although Goebel defined gross negligence as "a substantial departure" from the standard of care rather than "an extreme departure," this was simply a semantic difference.

Her testimony indicated she understood the difference between gross negligence and simple negligence, and she concluded that respondent was grossly negligent in a number of respects. Her conclusions were persuasive.

16. After being terminated from Parkview, respondent worked through a registry at Willow Tree Nursing Home in Oakland. That facility subsequently hired her for a full-time position and she has worked there ever since. This essentially mirrored her experience at Parkview, where she initially had worked through a registry and was later hired to a staff position. In a letter, Parkview's administrator stated that he had been "impressed by the personal care and compassion [respondent] gave to her patients" and that it was this kind of work that had convinced him to hire her as a full-time nurse.

17. Complainant submitted a certification showing the board had incurred costs of $13,576.75 in the investigation and enforcement of this case. This consisted of $9,165.75 in attorneys fees (63.75 hours at hourly rates of $139 in fiscal year 2004-05 and $146 in 2005-2006), $4,036 in investigative costs (24 hours at hourly rates of $144 in 2003-04 and $173 in 2004-05), and $375 in expert fees (five hours at a rate of $75 per hour).[1] The attorneys fees and expert witness fees are found to be reasonable.

The "Declaration of Investigative Costs" attached to complainant's certification showed hourly investigative rates of $120 for all 24 hours expended. The declaration was signed by a Department of Consumer Affairs supervising investigator on May 19, 2005. A handwritten entry on the document says, "Please see attached justification showing . . . hourly rate increase [to $144 for 2003-04 and $173 for 2004-05]." However, no such justification was attached. Because no justification was provided for what appears to be a retroactive increase in hourly investigative costs, it cannot be found that those increased rates are reasonable. The reasonable investigative costs are therefore found to be $2,880 (24 hours @ $120 per hour). Total reasonable costs are therefore found to be $12,420.75.

LEGAL CONCLUSIONS

1. Business and Professions Code section 2761, subdivision (a)(1), provides that the Board of Registered Nursing may take disciplinary action against a registered nurse who has committed gross negligence in carrying out usual licensed nursing functions.

2. As set forth in Findings 9 and 15, the following allegations of gross negligence were established: Respondent failed to appropriately assess Patient A and transfer her to the hospital, failed to prevent LVN Fabian from reinserting the G-tube without physician's

[1] The deputy attorney general's declaration in support of the cost certification contains a typographical error. It shows the hourly rate for the 2005-06 fiscal year as $139. However, the declaration shows the same number of hours and the same total charges as complainant's cost certification and it is apparent that the actual rate charged was, as shown in the cost certification, $146.

orders, and failed to document any general or abdominal assessments of the patient during her entire shift.

3. Although it is true that Mariner's job description for charge nurse places the responsibility for making patient assessments upon the charge nurse, this does not absolve respondent of responsibility. As Goebel testified, the RN supervisor was responsible for assessing patients for changes in their medical conditions. Thus, while the charge nurses had some assessment responsibilities, so did the RN supervisor. Here, Patient A had had a significant change in her medical condition, and respondent knew it. She knew Patient A's G-tube had been dislodged. She knew the night shift charge nurses had been unable to reinsert it. She personally witnessed the day shift charge nurse attempting, with some difficulty, to reinsert the tube. She knew reinsertion of the tube took at least 45 minutes. And she knew the tube that was inserted was smaller than the tube that had previously been in place. Despite this, respondent made no effort to personally assess the patient before or during reinsertion of the tube. Nor did respondent make any effort to have the patient transferred to an acute care hospital. As set forth in Findings 5 and 6, respondent recognized that this should have been done after the patient's G-tube was dislodged. She told this to the night shift charge nurse, Idem, and to the day shift charge nurse, Fabian. In fact, respondent three times told Fabian the patient should be transferred to the hospital, yet she nevertheless allowed Fabian to reinsert a G-tube and the patient to remain at Parkview.

Parkview's protocols clearly require physician's orders before a G-tube can be changed or replaced. Respondent's assertion that she assumed Fabian was acting in accordance with physician's orders is insufficient justification for her own failure to assure adherence to proper procedures.

While respondent was entitled to rely upon Fabian to make the primary chart entry concerning reinsertion of the G-tube, by her own testimony respondent assessed the patient four times during the course of the day shift, checking the patient's abdomen for changes.[2] Yet, despite the fact that charting a patient's care, treatment, and condition is an important function of a registered nurse, respondent made not a single entry in the patient's chart to document her assessments.

4. Respondent's failures in this case seemed to be borne more of a failure of supervision than from a lack of nursing skill or knowledge. Although she was the RN supervisor on the day shift, respondent seemed to make little effort to actually supervise the charge nurses on duty. Rather, respondent simply relied upon them to carry out their duties properly without any intervention from her. Even though Fabian three times failed to heed her advice to send Patient A to the hospital, respondent did nothing either to prevent Fabian from reinserting the G-tube or to require her to transfer the patient. Respondent passively

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[2] It is recognized that this testimony contradicts the statement respondent gave Parkview's director of nursing on September 23, 2003. Nevertheless, respondent's testimony is accepted at face value.

accepted Fabian's conduct. Even respondent's failure to chart her assessments of the patient appeared to stem from her belief that it was the charge nurse's responsibility, not her own, to make entries in the chart.

5. Considering the matters set forth above, as well as respondent's long and previously unblemished record as a nurse, it is determined that revocation of respondent's license would be an unduly harsh result, unnecessary to protect the public. The board's disciplinary guidelines (see title 16, California Code of Regulations, section 1444.5) provide that the recommended minimum penalty for gross negligence is a stayed revocation with three years' probation. That is appropriate in this case. Although the guidelines also recommend that optional condition 16D (formerly 19), requiring a therapy or counseling program, be included in cases that involved patient death, there is nothing to indicate such a condition would be warranted here. Nor are any of the other optional conditions warranted.

6. Business and Professions Code section 125.3 provides that a board may order a licensee found to have violated the licensing law to pay a sum not to exceed the reasonable costs of investigation and enforcement of the case. By reason of the matters set forth in Finding 17, cause exists pursuant to that section to require respondent to pay the board the sum of $12,420.75.

ORDER

Registered nurse license number 415461 issued to respondent Surinder Pal Kaur Rai is revoked. However, the revocation is stayed and respondent is placed on probation for three years on the following conditions:

SEVERABILITY CLAUSE – Each condition of probation contained herein is a separate and distinct condition. If any condition of this order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this order, and all other applications thereof, shall not be affected. Each condition of this order shall separately be valid and enforceable to the fullest extent permitted by law.

(1) **OBEY ALL LAWS** - Respondent shall obey all federal, state and local laws. A full and detailed account of any and all violations of law shall be reported by respondent to the board in writing within 72 hours of occurrence. To permit monitoring of compliance with this condition, respondent shall submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of this decision, unless previously submitted as part of the licensure application process.

(2) **COMPLY WITH THE BOARD'S PROBATION PROGRAM** - Respondent shall fully comply with the conditions of the Probation Program established by the board and shall cooperate with representatives of the board in its

Program. Respondent shall inform the board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license with the board, including during any period of suspension.

Upon successful completion of probation, respondent's license shall be fully restored.

(3) **REPORT IN PERSON** - Respondent, during the period of probation, shall appear in person at interviews/meetings as directed by the board or its designated representatives.

(4) **RESIDENCY, PRACTICE, OR LICENSURE OUTSIDE OF STATE** - Periods of residency or practice as a registered nurse outside of California shall not apply toward a reduction of this probation time period. Respondent's probation is tolled if and when she resides outside of California. Respondent must provide written notice to the board within 15 days of any change of residency or practice outside the state, and within 30 days prior to re-establishing residency or returning to practice in this state.

Respondent shall provide a list of all states and territories where she has ever been licensed as a registered nurse, vocational nurse, or practical nurse. Respondent shall further provide information regarding the status of each license and any changes in such license status during the term of probation. Respondent shall inform the board if she applies for or obtains a new nursing license during the term of probation.

(5) **SUBMIT WRITTEN REPORTS** - Respondent, during the period of probation, shall submit or cause to be submitted such written reports/declarations and verifications of actions under penalty of perjury, as required by the board. These reports/declarations shall contain statements relative to respondent's compliance with all the conditions of the board's Probation Program. Respondent shall immediately execute all release of information forms as may be required by the board or its representatives.

Respondent shall provide a copy of this decision to the nursing regulatory agency in every state and territory in which she has a registered nurse license.

(6) **FUNCTION AS A REGISTERED NURSE** - Respondent, during the period of probation, shall engage in the practice of registered nursing in California for a minimum of 24 hours per week for six consecutive months or as determined by the board.

For purposes of compliance with this section, "engage in the practice of registered nursing" may include, when approved by the board, volunteer work as a

registered nurse, or work in any non-direct patient care position that requires licensure as a registered nurse.

The board may require that advanced practice nurses engage in advanced practice nursing for a minimum of 24 hours per week for six consecutive months or as determined by the board.

If respondent has not complied with this condition during the probationary term, and respondent has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the board, in its discretion, may grant an extension of respondent's probationary period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation shall apply.

(7) **EMPLOYMENT APPROVAL AND REPORTING REQUIREMENTS** - Respondent shall obtain prior approval from the board before commencing or continuing any employment, paid or voluntary, as a registered nurse. Respondent shall cause to be submitted to the board all performance evaluations and other employment related reports as a registered nurse upon request of the board.

Respondent shall provide a copy of this decision to her employer and immediate supervisors prior to commencement of any nursing or other health care-related employment.

In addition to the above, respondent shall notify the board in writing within 72 hours after she obtains any nursing or other health care-related employment. Respondent shall notify the board in writing within 72 hours after she is terminated or separated, regardless of cause, from any nursing, or other health care-related employment with a full explanation of the circumstances surrounding the termination or separation.

(8) **SUPERVISION** - Respondent shall obtain prior approval from the board regarding her level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse, or education and training that includes patient care.

Respondent shall practice only under the direct supervision of a registered nurse in good standing (no current discipline) with the Board of Registered Nursing, unless alternative methods of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are approved.

Respondent's level of supervision and/or collaboration may include, but is not limited to the following:

(a) Maximum - The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

(b) Moderate - The individual providing supervision and/or collaboration is in the patient care unit or in any other work setting at least half the hours respondent works.

(c) Minimum - The individual providing supervision and/or collaboration has person-to-person communication with respondent at least twice during each shift worked.

(d) Home Health Care - If respondent is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with respondent as required by the board each work day. Respondent shall maintain telephone or other telecommunication contact with the individual providing supervision and/or collaboration as required by the board during each work day. The individual providing supervision and/or collaboration shall conduct, as required by the board, periodic, on-site visits to patients' homes visited by respondent with or without respondent present.

(9) **EMPLOYMENT LIMITATIONS** - Respondent shall not work for a nurse's registry, a temporary nurse placement agency, or an in-house nursing pool. Nor shall she work as a traveling nurse or in any private duty position as a registered nurse.

Respondent shall not work for a licensed home health agency as a visiting nurse unless the registered nursing supervision and other protections for home visits have been approved by the board. Respondent shall not work in any other registered nursing occupation where home visits are required.

Respondent shall not work in any health care setting as a supervisor of registered nurses. The board may additionally restrict respondent from supervising licensed vocational nurses and/or unlicensed assistive personnel on a case-by-case basis.

Respondent shall not work as a faculty member in an approved school of nursing or as an instructor in a board-approved continuing education program.

Respondent shall work only on a regularly assigned, identified and predetermined worksite(s) and shall not work in a float capacity.

If respondent is working or intends to work in excess of 40 hours per week, the board may request documentation to determine whether there should be restrictions on the hours of work.

(10) COMPLETE A NURSING COURSE(S) - Respondent, at her own expense, shall enroll in and successfully complete a course(s) relevant to the practice of registered nursing no later than six months prior to the end of her probationary term.

Respondent shall obtain prior approval from the board before enrolling in the course(s). Respondent shall submit to the board the original transcripts or certificates of completion for the above-required course(s). The board shall return the original documents to respondent after photocopying them for its records.

(11) COST RECOVERY - Respondent shall pay to the board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $12,420.75. Respondent shall be permitted to pay these costs in a payment plan approved by the board, with payments to be completed no later than three months prior to the end of the probation term.

(12) VIOLATION OF PROBATION - If respondent violates the conditions of her probation, the board, after giving respondent notice and an opportunity to be heard, may set aside the stay order and impose the stayed discipline (revocation) of respondent's license.

If during the period of probation, an accusation or petition to revoke probation has been filed against respondent's license or the Attorney General's Office has been requested to prepare an accusation or petition to revoke probation against respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been acted upon by the board.

(13) LICENSE SURRENDER - During respondent's term of probation, if she ceases practicing due to retirement or health reasons, or is otherwise unable to satisfy the conditions of probation, respondent may surrender her license to the board. The board reserves the right to evaluate respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances, without further hearing. Upon formal acceptance of the tendered license and wall certificate, respondent will no longer be subject to the conditions of probation.

Surrender of respondent's license shall be considered a disciplinary action and shall become a part of respondent's license history with the board. A registered nurse whose license has been surrendered may petition the board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision:

(1) Two years for reinstatement of a license that was surrendered for any reason other than a mental or physical illness; or

(2) One year for a license surrendered for a mental or physical illness.

DATED: February 15, 2006

MICHAEL C. COHN
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: SURINDER PAL KAUR RAI P.O Box 699 San Leandro, CA 94577 Registered Nurse License No. 415461 Respondent.	Case No. 2005-215 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1987, the Board of Registered Nursing issued Registered Nurse License No. 415461 to Surinder Pal Kaur Rai (Respondent). The Registered Nurse License will expire on November 30, 2006, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. Title 16, California Code of Regulations section 1442 provides, in pertinent part, that as used in section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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FIRST CAUSE FOR DISCIPLINE
Bus. & Prof. Code §2761(a)(1)
(Gross Negligence)

8. Respondent is subject to disciplinary action under Code section 2761(a)(1) in that respondent was grossly negligent within the meaning of Title 16, California Code of Regulations section 1442, when she failed to properly treat Patient A. Specifically, respondent was grossly negligent in that she failed to appropriately assess and notify a physician and/or transfer to a hospital an eighty year old patient whose feeding tube had dislodged, and failed to intervene to prevent a subordinate licensed vocational nurse (LVN) from attempting and completing reinsertion of the dislodged feeding tube into the patient without benefit of a physician's order. Respondent watched and assisted while a LVN whom she supervised, improperly reinserted the feeding tube in the patient. Said patient died the following day due to peritoneal sepsis from the improperly reinserted feeding tube. The circumstances are set forth hereinafter.

9. Respondent was employed as a Registered Nurse at Parkview Healthcare Center, a skilled nursing facility located in Hayward, California, during the relevant time period.

10. On or about September 21, 2003, at 6:55 a.m., the LVN on duty learned the Patient A, a severely impaired eighty year old patient, had removed her feeding tube. The LVN reported the incident to the night shift charge nurse. The LVN and charge nurse went into Patient A's room. The charge nurse determined Patient A's "stoma" was closed. She cleaned Patient A's stoma and applied a dry dressing.

11. On or about September 21, 2003, at 8:00 a.m., the LVN reported the incident to the incoming day LVN and respondent, RN supervisor of the day shift. The LVN tried to reinsert the feeding tube at least twice with respondent watching and holding Patient A's hand. The LVN did finally insert a smaller feeding tube in Patient A. The medicating, hydrating, and feeding of Patient A through the feeding tube resumed.

12. On or about September 21, 2003, at 4:45 p.m., the LVN on duty went to Patient A's room to administer insulin and noted her "abdomen was distended" (swollen and firm).

13. On or about September 21, 2003, at 11:20 p.m., patient A was transferred to St. Rose Hospital Emergency Room.

14. On or about September 22, 2003, patient A died due to sepsis from the intra-abdominal placement of the feeding tube and insertion of feeding material.

15. Respondent failed to properly treat Patient A as specifically set forth hereinafter.

(a) Respondent should have contacted Patient A's physician immediately for feeding tube reinsertion orders.

(b) Respondent should have a the physician's order before attempting reinsertion of a dislodged tube.

(c) If a physician is not available, respondent should have transferred Patient A immediately to a hospital for reinsertion of the feeding tube by a physician.

(d) Respondent should have recognized that Patient A's feeding tube could not be reinserted.

(e) Respondent did not follow Parkview's nursing protocols requiring a physician's order prior to feeding tube reinsertion attempts.

(f) Respondent failed to properly assess the symptoms of a severely impaired elderly patient. .

(g) Respondent should not have allowed a subordinate LVN to perform nursing tasks delegated to her.

(h) Respondent should not have allowed a smaller feeding tube to be inserted into Patient A.

(i) Respondent failed to document the reinsertion of the feeding tube on the patient's chart and failed to document any further general or abdominal physical assessments of the patient during the entire day shift.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 415461, issued to Surinder Pal Kaur Rai;

2. Ordering Surinder Pal Kaur Rai to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 6/13/05

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant